VIRGINIA DEPARTMENT OF HEALTH
INFORMED CONSENT FOR SPECIAL HEALTH SERVICES

_____
HEALTH DEPARTMENT/CENTER

_____ _____ _____
PATIENT NAME BIRTHDATE AGE

I hereby authorize the Physicians, Nurses, Nurse Practitioners, and/or other medical care providers of the Virginia Department of Health to examine and/or treat me and/or my dependent, as named above, with the following services/procedures.

I have been made aware of the risks and benefits associated with the following procedure(s) and have been given the opportunity to ask questions. If either I or my dependent child is to receive an immunization(s), I acknowledge that I have received Vaccine Information Statement(s) (VIS) about the immunization(s).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

This consent remains in effect as long as I receive care in this health department or until I withdraw it.

_____ _____
Signature of Patient, Parent/Legal Guardian, or Person Acting in Loco Parentis — Date Signed

_____ _____
Relationship (if signature is not of Patient) — Signature of Person Obtaining Consent

NOTE: To be used only when any one or more of the services/procedures listed on the reverse side is being delivered. Consent should be obtained by the provider of care.

CHS1B 1/95